STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G214	A. BUILDING _____ B. WING _____	01/10/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	5701 14TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This certification survey was initiated on January 10, 2007. As a result of the observations made to bring concern with client protection and safety, it was determined that the certification survey be aborted. Two males and one female currently reside at the facility. The first client was officially admitted into the facility on December 22, 2006. The female client attends a day program while the Administer indicated that day program locations would be sought for the others. Each of these clients had an ambulation deficient. Two of the clients used wheelchairs while the other was observed to use a walker. These clients had varying levels of mental retardation and medical diagnosis. According to the Qualified Mental Retardation Professional who reportedly had been hired to the facility on January 5, 2007, one client was received from the hospital, one had been residing with the family, and one had been transferred from another group home under the auspices of this provider. The preliminary findings derived from observation and staff interview warranted aborting the certification survey. It was recommended that this provider not receive certification at this time.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Susan Sloan RN, BSN, MA - VPO - Metro Homes, Inc

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 This STANDARD is not met as evidenced by: Based on inspection of client #3 ' s personal area, the governing body failed to ensure the safety of clients in the facility from neglect and potential harm. The finding includes: 1. During the inspection of client #3 ' s bedroom at 8:55 AM, an electric wall heater was observed behind the unoccupied bed. The bedroom had two beds and client #3 occupied one. The heater was " hot " to touch. The written warning on the heater indicated do not put near drapes, furnishing, etc. The bed had been situated in a way that the comforter touched the heater. The heater was hot and uncovered preventing the protection of clients from harm from possible fire. The governing body failed to ensure that the heating system was safe to ensure the protection of the clients residing in the facility. 2. The governing body failed to protect clients #1, #2, and #3 from harmful elements of the weather. (Refer to W149) 3. The governing body failed to ensure staff training on disaster evacuation from the facility. (Refer to W442)	W 104	W104 1 Client # 3's bed was immediately moved and a safety cover has been placed on the heater vent. Staff has been in-serviced with regard to ensuring that the heater vent is free and clear of objects that pose a fire risk. W104 2 Staff will be in-serviced and evaluated on the agencies Policy on client safety and protection.	1/12/2007 1/31/07
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.	W 125		

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W 125	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that client #3 ' s rights were protected. The finding includes: Upon the surveyor ' s arrival to the facility and up to twenty minutes later, the back door of the facility was observed to be opened. It was determined that clients and staff were entering and exiting from client #3 ' s bedroom. There was no evidence that client #3 ' s private area was being respected. It could not be determined that client #3 had advocacy to ensure his rights were presented and acknowledged.	W 125	W125 In the future client #3's bedroom will not be utilized to enter or exit and staff have been in-serviced with regard to the above. Inadditionclient#3's rights have been reiterated and signed.	1/31/07
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, the direct care staff failed to ensure that all clients in the sample received the goods/services by competent staff necessary to avoid physical harm. The finding includes: 1. According to T.V. station Fox 5, the temperature outside was 32 degrees at 8:45 AM. On January 10, 2007, at 8:10 AM, the staff was observed to have three clients in the sample	W 149		

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W 149	Continued From page 3 inappropriately dressed for the elements of weather as detailed below: a. Client #1 was being mobilized in her wheelchair by a male staff. The client was observed to have her coat unzipped and open to see her short sleeve shirt and she was not wearing a hat. The client was observed to be outside for twelve minutes while waiting for the van that later arrived to escort her to her day program. It was not until the surveyor intervened that the client ' s coat was closed. b. Client #2 was observed coming down the alley way alone wearing his coat opened with a regular shirt on and without a hat. This client also wore closed in house-shoes with socks. Once client #2 returned to the facility, he verbalize to the surveyor that he was cold. c. Initially, client #3 had not been seen. The client had been on the van for approximately 15 minutes that the surveyor was present. The engine of the van was not on. After being taken from the van by the House Manager, the client was observed wearing no hat and a leather jacket that was zipped. It should be mentioned that the male staff had on a nylon jogging suit jacket; however, the house manager and another staff had on winter coats with hoods and one wore a hat. The clients ' personal areas were inspected and it was found that the clients had sweater, hats, and other items appropriate for the cold weather. There was no evidence that the staff had considered the health and safety repercussions of having the clients out in the weather without being	W 149	W149 1a, b, c, d Residential staff will be in serviced on agency's policy with regard to abuse and neglect in conjunction with DDS policies. Staff will also be in serviced with regard to ensuring that client #1, 2, and 3 are dressed appropriately for weather conditions.	1/31/07

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W 149	Continued From page 4 dressed for the extreme cold weather. 2. A second van arrived at approximately 8:35 AM. Client #1 was taken from her wheelchair and assisted by two staff to get on the van. The van proceeded without client #2 being secured in a seatbelt.	W 149	W149 2 Staff will be in serviced with regard to van safety for client #1 and all the other consumers.	1/31/07
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on review of the presented staff schedule and interview with the House Manager, the facility failed to demonstrate that adequate number and trained staff was present to ensure that the needs of clients could be met. 1. According to the written staffing schedule presented to the surveyor, shifts were identified; however, only two staff names were listed on the schedule. The House Manager verbally indicated the names of seven staff upon inquiry about how many staff were scheduled to this facility. The names were not on the schedule; therefore, it could not be determined that the facility had sufficient staff hired to this facility to ensure that clients ' needs would be met. 2. According to the House Manager two staff were scheduled on each shift. It was observed that the three clients currently residing in the	W 186		

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W 186	Continued From page 5 facility had ambulation deficient. One client used a walker and two used wheelchairs for mobility. During the fire drill conducted at 8:55 AM the two clients in the facility required one to one assistance. It could not be determined that sufficient staff would be available to assist if the nurses were not available and had client #1 been in the facility.	W 186	W186 1, 2 The Staffing schedule will be revised and modified to reflect the names of staff and staffing pattern based on the need of the consumers in the residence.	1/14/07
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on review of the training record, the facility failed to provide documented evidence of staff training to ensure competency in performing their job duties to protect clients in the facility. The finding includes: 1. There was no evidence that staff had been trained on incident reporting procedures, handling emergencies, neither specific clients needs at the time of the survey. There was a document of signatures showing that three staff had been trained on December 21, 2006 on " emergency procedures " , who to call, procedures, ensuring client safety. There was no agenda to describe the specifics of what was discussed. (Refer to W 186 #1) 2. Refer to W149.	W 189	W189 1 The Staff Training Manual which outlines and provides a list of all trainings that staff have participated in will be maintained in the residence for review.	1/12/2007
W 442	483.470(i)(1)(i) EVACUATION DRILLS The facility must hold evacuation drills to ensure	W 442		

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W 442	Continued From page 6 that all personnel on all shifts are trained to perform assigned tasks. This STANDARD is not met as evidenced by: Based on observation, the facility failed to demonstrate staff competency in evacuating clients in the safest manner. The finding includes: During a fire drill initiated by the Fire Inspector, the Director of Nursing, the Registered Nurse for the facility and a direct care staff escorted clients #2 and #3 to the outside safe zone. The clients were exited from the facility using client #3 ' s bedroom. Client #3 ' s bed was moved twice due to it impeding the clients ' exiting. The clients were positioned in the living room at the initiation of the fire drill. The escorts failed to use the nearest exit to them for evacuation. The records for staff training on staff responsibilities during emergencies were not available in the facility.	W 442	W442 All staff working with the clients will be in-serviced in Fire and Safety / Evacuation.	1/31/07

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
ICF/MR DIVISION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Metro Homes Inc.	5701 14th Str. NW Washington, DC 20011	1/10/07 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
	This licensure survey was initiated on January 10, 2007 at 8:00 AM. in conjunction with a certification survey. The survey was aborted on the same day by 12:00 PM following contacts with the area licensing office. There were several concerns regarding clients' safety and protection and staff training. The findings were derived from observation and staff interview. These deficiencies are outlined throughout this report.			
3505 3505.4	**FIRE SAFETY** Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (1) The instructions and plans that re to be followed in case of fire, explosion, or other emergency; (2) The persons to be notified; (3) The location of alarm signals; (4) The locations of fire extinguishers; (5) The evacuation routes;		3505.4 Fire and Safety Book outlining the Fire Alarm System operation procedures and location, The evacuation Plan and Emergency Contact, Standard Operating Procedures and Frequency of fire drills and record of training will be readily accessible to staff and residents.	1/31/07

√ Name of Inspector — 1/10/07 Date Issued

Facility Director/Designee — 1/25/07 Date
Susan J. Sloan RN, BSN, MA
Vice President of Operations

DA

incident reporting procedures, handling emergencies, neither specific clients needs at the time of the survey. There was a document of signatures showing that three staff had been trained on December 21, 2006 on "emergency procedures", who to call, procedures, ensuring client safety. There was no agenda to describe the specifics of what was discussed.

2. According to T.V. station Fox 5, the temperature outside was 32 degrees at 8:45 AM. On January 10, 2007, at 8:10 AM, the staff was observed to have three clients in the sample inappropriately dressed for the elements of weather as detailed below:

A. Client #1 was being mobilized in her wheelchair by a male staff. The client was observed to have her coat unzipped and open to see her short sleeve shirt and she was not wearing a hat. The client was observed to be outside for twelve minutes while waiting for the van that later arrived to escort her to her day program. It was not until the surveyor intervened that the client's coat was closed.

B. Client #2 was observed coming down the alley way alone wearing his coat opened with a regular shirt on and without a hat. This client also wore closed in house-shoes with socks. Once client #2 returned to the facility, he verbalize to the surveyor that he was cold.

C. Initially, client #3 had not been seen. The client had been on the van for approximately 15 minutes that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	(6) The frequency of fire drills; (7) The assignment of specific tasks and responsibilities to the staff of each shift; and (8) The name and address of the owner of the group home if the owner is neither the licensee nor the operator; (b) Records of the training of all personnel who are to perform the specific tasks designated in the manual described in paragraph **The finding includes:** During a fire drill initiated by the Fire Inspector, the Director of Nursing, the Registered Nurse for the facility and a direct care staff escorted clients #2 and #3 to the outside safe zone. The clients were exited from the facility using client #3's bedroom. Client #3's bed was moved twice due to it impeding the clients' exiting. The clients were positioned in the living room at the initiation of the fire drill. The escorts failed to use the nearest exit to them for evacuation. The records for staff training on staff responsibilities during emergencies were not available in the facility.			
3510 3510.4	**STAFF TRAINING** Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. **The findings include:** 1. There was no evidence that staff had been trained on		3510.4 Refer to W125, W189, and W442 of federal deficiency report POC.	1/31/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	surveyor was present. The engine of the van was not on. After being taken from the van by the House Manager, the client was observed wearing no hat and a leather jacket that was zipped. It should be mentioned that the male staff had on a nylon jogging suit jacket; however, the house manager and another staff had on winter coats with hoods and one wore a hat. The clients' personal areas were inspected and it was found that the clients had sweater, hats, and other items appropriate for the cold weather. There was no evidence that the staff had considered or had been trained on the health and safety repercussions of having the clients out in the weather without being dressed for the extreme cold weather. 2. A second van arrived at approximately 8:35 AM. Client #1 was taken from her wheelchair and assisted by two staff to get on the van. The van proceeded without client #2 being secured in a seatbelt. There was no evidence of staff training of vehicle safety.			
3510.5	Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills.		3510.5 Refer to W189 1 of the federal deficiency report POC.	1/31/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(b). Human development through the life cycle (birth to death);

© (Infection control for staff and residents;

(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;

(e) Resident's rights;

(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;

(g) Habilitation planning and implementation;

(h) Orientation programs for each new employee which shall include philosophy, organization, programs, practices and goals of the GHMRP as well as a review of applicable laws, regulations and agreements important to the operation of the GHMRP for the care and treatment of persons with mental retardation in the District of Columbia; and

(i) (Training of the residents in the maintenance of oral health and hygiene.

The findings include:

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
ICF/MR DIVISION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	1. There were no training records available at the facility in relations to the above identified areas. 2. Refer to federal deficiency report W125 (client rights); W189 (staff training, W442 (evacuation)			
3513 3513.1	**ADMINISTRATIVE RECORDS** Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: c) Weekly staff schedules, including substitutions; **The finding includes:** According to the written staffing schedule presented to the surveyor, shifts were identified; however, only two staff names were listed on the schedule. The House Manager verbally indicated the names of seven staff upon inquiry about how many staff were scheduled to this facility. The names were not on the schedule; therefore, it could not be determined that the facility had sufficient staff hired to this facility to ensure that clients' needs would be met.	3513 Refer to W186 1 and 2 of the POC.	1/31/07
3519 3519.2	**EMERGENCIES** Each GHMRP shall maintain written documentation that each employee has been trained in carrying out the policies and procedures set forth in § 3519.1 of this section. **The finding includes:** There was no evidence that staff had been trained on incident reporting procedures, handling emergencies, neither specific clients needs at the time of the survey. There was a document of signatures showing that three staff had been trained on	3519.2 The Staff Training Manual which outlines and provides a list of all trainings that Residential Staff have participated in will be maintained in the residence for review	1/31/07

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
ICF/MR DIVISION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	December 21, 2006 on "emergency procedures", who to call, procedures, ensuring client safety. There was no agenda to describe the specifics of what was discussed.			
3523 3523.1	**RESIDENT'S RIGHTS** Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. **The findings include:** Refer to federal deficiency report (W149, policies to prevent neglect and rights to safety; W125 protection of clients' rights.		3523.1 Refer to federal defiency report W125, W149 - POC	1/31/07